CareFirst BlueCross BlueShield

Consumer-Driven Health Plans

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Consumer-Directed Healthcare (CDH) Overview

CDH is a high deductible health plan (HDHP) paired with a tax-preferred savings account which is used to pay for qualified healthcare expenses.

The CDH CONCEPT

- Require all medical and Rx benefits to be subject to a high deductible
- Encourage members to seek preventive care by allowing that care to be covered at 100%
- Tie these high deductible plans to tax preferred savings accounts that allow members to save pre tax money to cover the cost of the deductible and other out of pocket costs
- Integrate the health care benefits with the administration of these savings accounts
- Provide online tools to help members make informed decisions
- Create wiser, more informed consumers who make better healthcare choices because they pay more out of pocket and want to save money

Health Savings Accounts

- An HSA is a portable, tax-advantaged bank account, funded by the employee and/or employer
- The bank account is in the employee's name. Any unused funds roll over each year.
- No tax on funds when they are deposited, no tax on earnings, and no tax when funds are used for qualified healthcare expenses
- To establish an HSA, members must be in an HSA-compliant HDHP as determined by the IRS
- After reaching a specified balance, HSA funds can be invested, similar to 401k plans

Health Reimbursement Arrangements

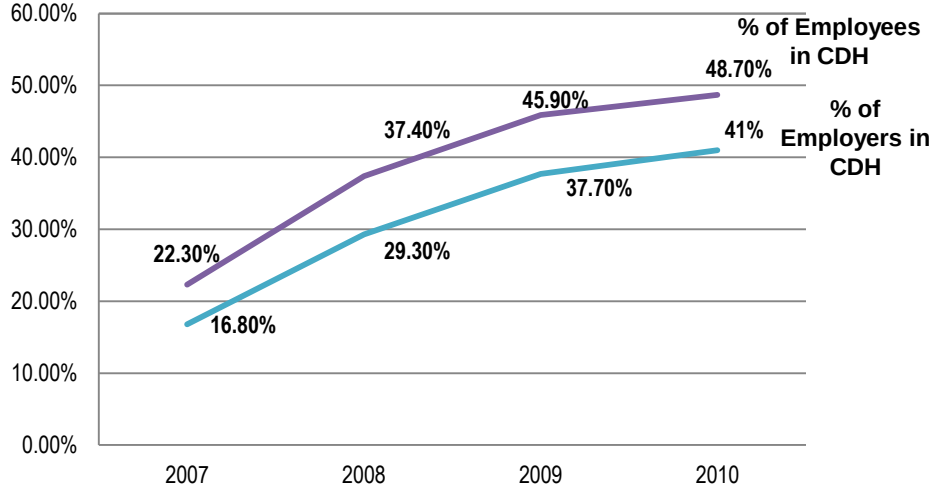
- HRAs are employer-owned "accounts" used to reimburse employees for eligible medical-related expenses on a non-taxable basis
- HRAs are solely funded by the employer who "allocates" contributions to employees' HRAs
- Regulations allow a great deal of benefit plan design flexibility. Combined medical and Rx deductibles and high deductibles are not required, although common.
- Employer pay claims for qualified expenses as they are incurred
- Unused funds may rollover (employer decision)

What Happened and Where it Happened

We have seen in the market one of the most remarkable transformations, and in the most regulated segments – Maryland Small Group and Individual <65

- In the CareFirst region, the move to CDH occurred in the most vulnerable, price sensitive segments – Maryland Small Group and Individual <65.
- We observed unprecedented growth of CDH in the Maryland Small Group Market. The Small Group Employer CDH adoption rates grew from 17% in 2007 to 41% in 2010.
- The Maryland Small Group Reform (MSGR) market has the highest penetration of CDH, representing 58% of MSGR enrollment. The Individual <65 segment penetration is 28%.
- In Small Group, CDH premiums averaged 45-60% less than Non-CDH in 2008 and average 29% -54% less today.
- CDH mainstreamed much faster than expected because **it was too good to pass up.**

Maryland Small Group Reform (MSGR) Shift to CDH



CDH Contracts

	Contracts (as of Sept 2011)	% of Total Segment
2-50 MSGR	80,506	58%
Individual <65	26,941	28%
2-50 Non-MSGR	10,987	12%
Group 51-199	18,951	17%
Group 200+ Risk	7,813	3%
Non-Risk	15,826	2%
Total	142,561	9%

Cost Variance Between CDH and Non-CDH in Small Group

Average Monthly Individual Rate		
	1/1/2008	1/1/2012
PPO	60%	54%
HMO	45%	29%

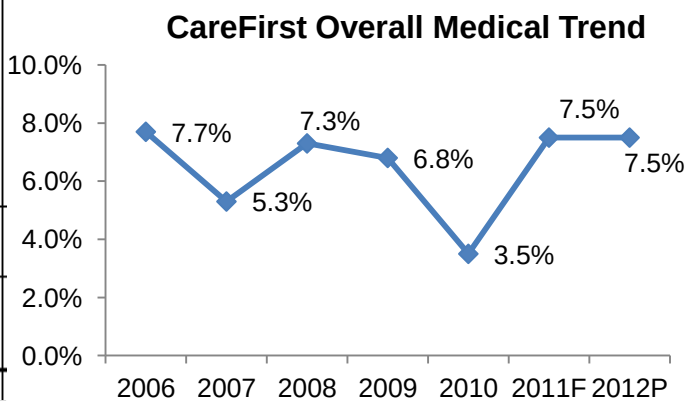
How Much Cost Was Shifted

With the higher deductibles associated with CDH plans, a massive potential cost shift to the member occurred.

- Over the past several years, there has been a massive shift in the market, particularly among CareFirst customers, to high deductible CDH products in an effort to contain costs – first because medical care cost trends were rising substantially (mid-2000s) and then because the tough economic climate made coverage more difficult to afford for both groups and individuals.
    - Prior to CDH products entering the market, benefit buy-downs were already underway with higher deductibles and copays and in some markets the move away from PPOs to HMOs.
- These buy downs created huge gaps. The shift is estimated at $1B in additional burden to the member over the 2007-2010 timeframe.
- The thought behind the shift was it would cost sensitize people more, make them more cautious and wise in seeking health care services. This has been difficult to prove.
- **Care utilization dropped in 2010 and early 2011. But this had more to do with the down turn in the economy then on the impact of high deductibles.**

Historic Premium Yields – "Buy Down Impact"

		2007		2008		2009		2010		2011	
Market	Product	Approved Renewal Rate Δ	Revenue Yield PMPM vs. Prior Yr.	Approved Renewal Rate Δ	Revenue Yield PMPM vs. Prior Yr.	Approved Renewal Rate Δ	Revenue Yield PMPM vs. Prior Yr.	Approved Renewal Rate Δ	Revenue Yield * PMPM vs. Prior Yr.	Approved Renewal Rate Δ	Revenue Yield ** PMPM vs. Prior Yr.
Individual < 65	HMO (NonCDH and CDH)	4.1%		14.2%		18.0%		18.2%		7.7%	
	PPO + Indemnity (NonCDH and CDH	6.8%		10.1%		14.9%		17.8%		4.5%	
	Subtotal:	**6.3%**	**2.5%**	**10.8%**	**4.0%**	**15.4%**	**4.9%**	17.8%	**7.1%**	5.1%	**4.9%**
Individual >65	Medigap	7.7%	4.3%	8.2%	6.9%	5.7%	5.6%	9.1%	8.7%	5.1%	4.0%
Small Group - MSGR	HMO (NonCDH)	8.9%		10.8%		13.9%		10.6%		-4.1%	
	PPO + Indemnity (NonCDH)	6.8%		10.5%		9.6%		4.0%		6.8%	
	CDH (HMO-PPO)	13.5%		15.1%		17.5%		17.8%		-0.9%	
	Subtotal:	**9.1%**	**-0.3%**	**12.0%**	**-0.7%**	**14.6%**	**5.6%**	**12.7%**	**7.8%**	**-0.8%**	**2.2%**



* 2010 YTD revenue yield reflects December 2010 Actual PMPM/ December 2009 PMPM (trailing 12 months).
** Expected PDR is subtracted from 2011 Revenue.
*** Not all rates have been approved. These increases reflect the most recent proposals if not yet approved.

Mitigations to the Cost Shift

The effects of cost shifting to the member have been significantly mitigated due to several factors

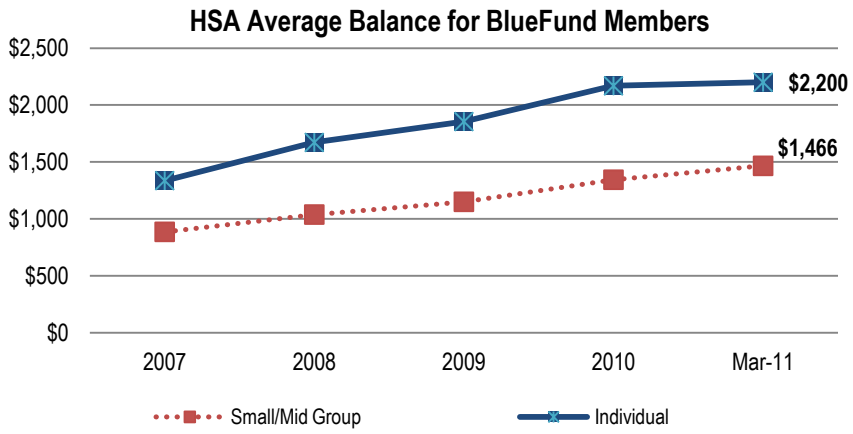
- Factors that significantly mitigated the cost shift
  - Members pay less toward their premium because the CDH premium is lower, and that savings can be used to fund the HSA
  - Employers use their savings in premiums to contribute money to the HRAs and HSAs to help offset the move to higher deductibles
  - Members experience savings on Federal taxes when they contribute to the HSA. And group members also incur State and FICA tax savings
  - Preventive Care is not subject to the deductible, and now with Affordable Care Act must be covered at 100%

- Employers that have been offering CDH plans for a few years continue to contribute to their employees' HSAs accounts at a higher rate each year. Employers that have been offering CDH since 2006 have an average employee contribution for individual and family policies of almost $1800

- The average account balance for a BlueFund HSA small/mid sized group member is almost $1,500. The average account balance for an Individual member, who contributes on their own since they are not enrolled through an employer, is even higher at $2,200. These balances are higher than our most popular deductible plan ($1200), which means that these members have saved enough money to cover the cost of their deductible

- As of January 1, 2011, CareFirst's account holders had more than $44M in HSA deposits. Nationally, the amount in deposits for HSAs is $11.3B.

- So the theory behind the CDH cost shift – being wiser with your money because now you have skin in the game – was undermined because **employers funded the deductibles at such a high percentage that members had first dollar coverage for the cost of a high deductible premium.**



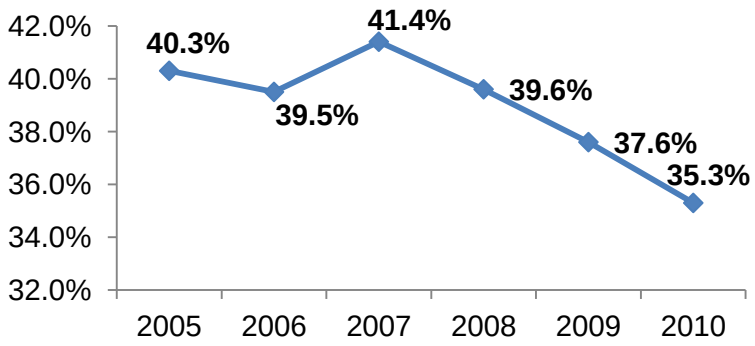
Original Effective Year	Average Employer Contribution per Employee			
	Dec. 31, 2007	Dec. 31, 2008	Dec. 31, 2009	Dec. 31, 2010
2006	$1,538	$1,683	$1,693	$1,779
2007	$1,297	$1,414	$1,559	$1,613
2008	N/A	$1,150	$1,373	$1,414
2009	N/A	N/A	$1,110	$1,287

What Has Been the Impact

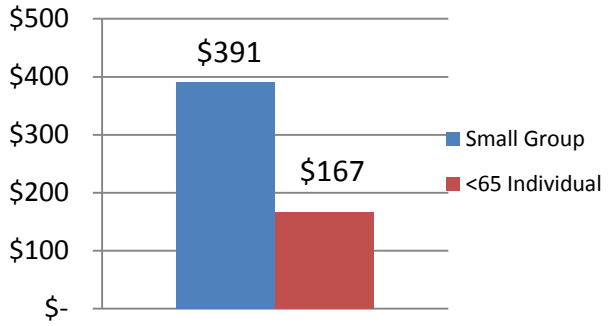
Maryland Small Group is a Market that is shrinking and employers are dropping coverage because they can't afford it.

- The percent of Maryland Small Group employers offering insurance has fallen from 41% in 2007 to 35% in 2010.
- Members in the <65 Individual market pay on average 57% less for a CDH plan vs. a Maryland Small Group member. This is attributed to medical underwriting (more favorable risk), which goes away in 2014
- Once a group or individual selects CDH, most either remain in CDH or go uninsured. Of the individuals who had CDH but left CareFirst, 37% moved to CDH with another carrier and 38% went uninsured. In small group 62.5% of employers moved to CDH with another carrier and 17.5% dropped coverage.
- **So, the last stop before dropping insurance is CDH. And with CDH making up 58% of the MSGR, those groups are potentially one step away from dropping coverage**.

% of Maryland Small Group Offering Insurance



1/1/2012 Composite CDH Premium MSGR vs. <65 Individual



2010 CareFirst Lost Survey Results		
Had CDH with CareFirst	Moved to CDH with another Carrier	Dropped Coverage
Individual <65	36.7%	38%
2-50 Group	62.5%	17.5%

Impact of State Exchanges

Will a key source of funding health insurance be eliminated, or at least diminished?

- Product offerings must conform to uniform standards – resulting in little differentiation on anything except price.

- The dynamic could lead to a sizable employer movement to Defined Contribution.
  - An Exchange provides the mechanism that may accelerate account movement from Defined Benefit to Defined Contribution
  - Employees are offered a greater array of product choices including ancillaries to meet their needs
  - Employers preserve the tax advantage for providing insurance
  - Employer provides a defined dollar amount to be used toward the cost of the employee premium
  - Employee premiums will be based on individual ages as opposed to the average age of the group. This means that younger employees will see their rates decrease while older employees will see their rates increase. The 3:1 rate bands will help mitigate this change.

- CDH has perfectly teed up employers for defined contribution because they have already been providing defined dollar amounts into HSAs and HRAs for the past 5 years.
  - It is still not clear whether a plan's actuarial value will include employer or individual contributions made to the individual's HSA. The Secretary of HHS needs to issue regulations on this matter. In addition, because the Essential Benefits are still not defined we don't know if the Secretary of HHS will require HSA plans to cover benefits, besides preventive, that are not subject to the deductible

- With the exchange offering member choice and fueling Defined Contribution, a paradigm shift is likely, similar to that seen in the pension market with the growth of 401ks vs. pension plans.

- On average, employers in MSGR are paying 48% of the employees' premium. In addition to premium contribution, many employers are also making contributions into HRAs and HSAs

- As employers move to a Defined Contribution model, the key question is what are they likely to contribute? Will this diminish employer support and partially **dry up a key source of funding for health insurance?**

Conclusion

A collection of forces have been set in motion and no one knows for sure how it will play out

- **It is not likely that CDH is going to control overall medical trend since member out of pocket costs are highly mitigated.**
- **Defined Contribution will increase choice for the employees, which will fracture employer risk pools among carriers making it more unpredictable and harder to price.**
- **Defined Contribution begins to desensitize employers' from the true cost of health insurance and may result in employees picking up an increasingly large share of the cost.**
- **This is a major paradigm shift. After WWII we spent decades building up employer sponsored coverage. Now we are moving choice and accountability to the employee side.**
- **HealthCare Reform addresses the financing of and access to health insurance, but not the forces that are the real cause of increased cost.**
- **Controlling medical costs must be addressed; HealthyBlue and Patient Centered Medical Home influence healthy behavior through value based benefits, steerage to more efficient providers and an alignment of member and provide incentives.**